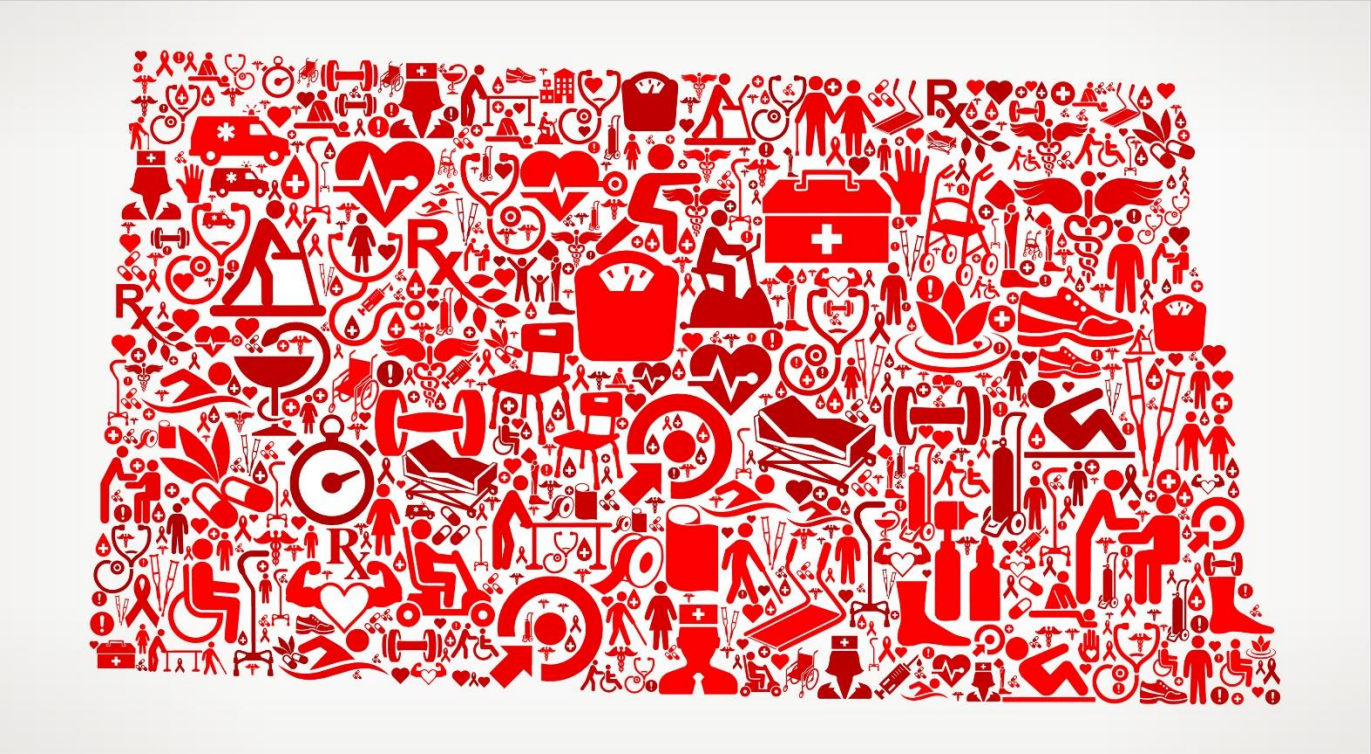
North Dakota Department of Health

Biennial Evaluation Plan for the Statewide Comprehensive Tobacco Control Program, FY2018-2019



Prepared by Professional Data Analysts, Inc. (PDA) | September 2018

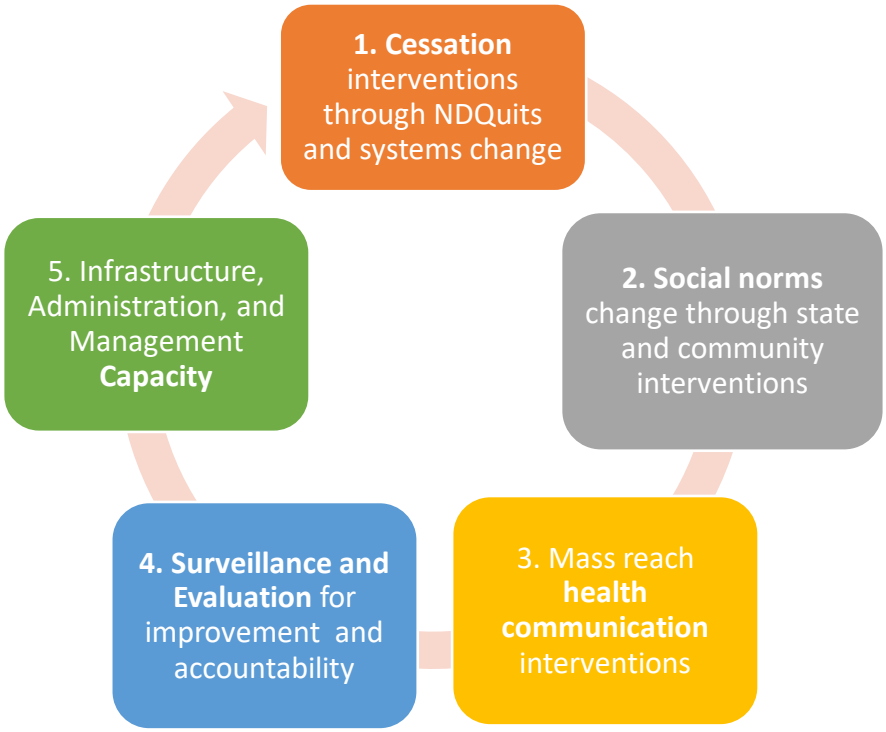
NORTH DAKOTA DEPARTMENT of HEALTH

PDA

Overview and Biennial Priorities

Tobacco use remains the number one cause of preventable death for North Dakotans, annually costing the state $559 million in direct medical expenditures and lost productivity related to tobacco use[1]. Further, some priority populations are disproportionately targeted and affected by tobacco, including American Indians, pregnant women, young adults (age 18-24), residents with behavioral health issues, and residents who identify as LGBTQ.

In an effort to reduce tobacco use and improve the health of all North Dakotans, the North Dakota Department of Health (NDDoH) has developed a State Tobacco Plan with specific goals and indicators for the 2017-2019 biennium, the North Dakota Comprehensive Tobacco Prevention and Control State Plan (State Plan) (Appendix C). This plan is based on evidence-based practices as put forth by the U.S. Preventative Services Taskforce, the Centers for Disease Control, and the National Institutes of Health. The five components of evidence-based comprehensive, statewide tobacco control are:



NDDoH is the primary agency responsible for implementing and ensuring the quality and effectiveness of a comprehensive tobacco control program. This role was expanded in May 2017, when the North Dakota Legislature voted to defund The North Dakota Center for Tobacco Prevention and Control Policy, also referred to as "The Center," which had previously been responsible for work in prevention, social norms, and health communications. Prior to this legislative action, North Dakota was funded at the CDC-recommended levels – one of two states in the nation to do so. However, with the closing of The Center, the budget for tobacco control in the state was cut by $3.2 million in fiscal year 2018[2]. Ultimately,

[1] Tobacco's Toll on North Dakota, 2017. Tobacco Fact Sheet, https://www.ndhealth.gov/tobacco/Facts/TollOfTobacco.pdf
[2] http://www.kfyrtv.com/content/news/Breathe-ND-snuffed-out-422391574.html

NDDoH is now responsible for all five areas of tobacco prevention and control in the state with half the budget and one-third of the staff. The Center employed nine staff and NDDoH was provided resources to hire one new full-time staff. Intentional and ongoing strategic planning has been underway in the state to ensure priorities are appropriately set and resources allocated to creatively optimize opportunities to affect positive change toward a tobacco free North Dakota.

To support efforts to document the processes implemented, lessons learned, and to document outcomes, NDDoH has contracted with Professional Data Analysts (PDA). PDA is a Minneapolis-based evaluation firm that specializes in evaluation of public health programs, with a particular expertise in evaluating tobacco control efforts. PDA has been contracted by NDDoH in the past to evaluate cessation efforts, including NDQuits, systems-change work through NDQC grants, and the BABY & ME - Tobacco Free™ (BMTF) initiatives. PDA has also evaluated the health communications efforts in North Dakota in the past.

For the 2017-2019 biennium, PDA is contracted to plan, implement, and report on an evaluation of all five areas of best practices tobacco control activities. These efforts will include formative and summative evaluation processes and deliverables. PDA takes a utilization-focused[3] approach to evaluation, engaging the primary users of the evaluation from planning through use of results. The quality of our evaluation is guided by The Program Evaluation Standards[4], and we strive to ensure our evaluations take into consideration issues of feasibility, accuracy, propriety, utility, and accountability.

Tobacco Control in North Dakota and Organization of this Document

Approximately half of North Dakota residents live in rural areas, which has two immediate implications for the programming efforts around tobacco. First, rural residents are more likely to use tobacco in North Dakota. Further, there is a larger number of smokeless tobacco users as compared to other US states[5]. Second, efforts to communicate prevention, cessation, and other educational efforts need to consider the dispersion of residents across the state to plan strategies that will effectively and efficiently reach all residents. Creative efforts need to be implemented and then documented and synthesized in the evaluation efforts. As one exemplar, two health educators in Fargo led students in the "Great American Spit Out," a play off of the well-known Great American Smokeout that is more focused on non-combustible forms of tobacco[6].

A strategic planning effort was organized and launched immediately in the biennium, which included formation of workgroups with representation from local public health units (LPHUs), tribal grantees, state and regional partnerships (e.g., American Lung Association, Campaign for Tobacco Free Kids, etc.), other state agency partners (e.g., Synar at the North Dakota Department of Human Services[7]), and NDDoH leadership. Further, partners and experts in the tobacco control realm were brought in to facilitate this process. The result of these planning efforts was an updated North Dakota Comprehensive Tobacco Prevention and Control State Plan (State Plan – Appendix C). This evaluation plan takes into

[3] Utilization-focused evaluation, http://www.utilization-focusedevaluation.org/
[4] The Program Evaluation Standards, Statements, http://www.jcsee.org/program-evaluation-standards-statements
[5] The Truth Initiative, https://truthinitiative.org/tobacco-use-north-dakota
[6] Great American Spit Out (local news): http://www.kvrr.com/2018/02/22/health-educators-raise-awareness/
[7] What is Synar? https://prevention.nd.gov/sites/default/files/pdf/SynarHandout.pdf

consideration the priorities set out in the State Plan, and results will be reported to NDDoH related to progress made toward the Plan's four goals.

Efforts in tobacco control are facilitated by multiple partnerships, vendors, and grantees to implement a multi-component initiative across the state. Briefly, these efforts include:

1. Cessation Interventions

   North Dakota has multiple initiatives focused on cessation. This includes the state telephone and web cessation service, NDQuits; quality assurance and data coordination with the quitline vendor; the BMTF program for pregnant women; and the NDQuits Cessation (NDQC) grantees that are working to implement systems changes in hospitals across the state. Key partners include the quitline vendor, the quitline counselors at the University of North Dakota (UND), and the NDQC and BMTF grantees.

2. State and Community Interventions

   This primarily includes prevention and social norms change work that is implemented across the state by the 28 (LPHUs) and the tribal grantees. The priorities of this work involve youth engagement, policy work around smoke-free places, health communications, referrals to NDQuits, and local coalition building.

3. Health Communication Interventions

   The primary focus of health communications work, particularly by NDDoH's media vendor, is on promotion of cessation interventions (NDQuits). The LPHUs are also engaged in local health communications around cessation, prevention, and social norms. Efforts include broadcast media (television, radio), social media (Facebook), earned media, and other print (e.g., billboards, pamphlets, etc.). Other key partners are the Public Education Task Force (PETF), Tobacco Free North Dakota (TFND), and various local partners and coalitions. The BreatheND brand will be continued; considerable resources were put into development of this brand by PETF, and it will be rebranded to emphasize the role of local public health in statewide tobacco control efforts.

4. Surveillance and Evaluation

   These efforts involve multiple entities, but are primarily led by the Tobacco Prevention and Control Program's epidemiologist and the external evaluator vendor, PDA. This involves the coordination of data collected by various grantees, vendors, and other agencies, as well as primary data collection efforts (e.g., follow-up surveys of NDQuits users, interviews) to track short-term and longer-term results of tobacco control programming and policies. The purposes of the evaluation are formative, descriptive (monitoring trends), and outcomes oriented to understand the impact of tobacco control efforts in the state.

5. Infrastructure, Administration, and Management

   This includes the capacity to implement and evaluate a comprehensive tobacco control program across the state. Of consideration is the capacity of NDDoH, as well as the capacity of key partners, vendors, and stakeholders, including PETF, TFND, LPHUs, the various grantees, and

state, regional and national partners (e.g., American Lung Association, American Heart Association, Campaign for Tobacco Free Kids, etc.). A sustainability effort was launched early in fiscal year 2019, as were workgroups focused on priority areas.

The evaluation is organized around these five best practice areas. Overall evaluation questions are also proposed within section 4, evaluation and surveillance. The details of the evaluation plan are in the following sections, though more nuanced details and methods are included within the specific evaluation reports that are created and disseminated. Interested parties can contact NDDoH or PDA for additional questions or information needs.

Evaluation Questions, Data Sources, and Methodology

To develop this evaluation plan, PDA drew upon best practices in tobacco control, as well as direct experience evaluating tobacco control programs in multiple states, including North Dakota, Minnesota, Oklahoma, Connecticut, Hawaii, and Florida. PDA is also guided by ethics and standards of the American Evaluation Association (AEA), including the Guiding Principles for Evaluators, the Cultural Competency Statement of AEA, as well as the Joint Committee for Educational Evaluation's five Program Evaluation Standards[8]. This means that PDA strives to ensure that our evaluations keep in mind issues of accuracy, feasibility, propriety, accountability, and utility.

PDA's approach to evaluation is driven by identifying the needs of the primary stakeholders and intended users – what are the intended uses of the evaluation? What are the information needs of the intended users? Evaluation activities are prioritized based on the information needs of these intended users. This approach is well documented in the evaluation literature and PDA has had much success in following this utilization-focused approach[9,10] for multiple decades.

Evaluation purposes, guiding questions, methods, analysis, and reporting will be detailed for each of the five best practice areas. Further details are provided in the appendices.

❶ Cessation Interventions

There are four primary evaluation activities that occur related to three cessation programs: NDQuits, NDQC grantees (systems change), and BMTF (pregnant women). These efforts have been led and managed by NDDoH for many years. The guiding evaluation question across all three cessation initiatives is: *To what extent is North Dakota implementing "population-level, strategic efforts to reconfigure policies and systems in ways that normalize quitting and that institutionalize tobacco use screening and intervention within medical care*?[11]"

The guiding evaluation questions for each of these four evaluation activities are listed in the following sections. Brief descriptions for programmatic efforts and key contextual information is provided as needed.

[8] Program Evaluation Standards, http://www.jcsee.org/program-evaluation-standards-statements
[9] Patton, M.Q. (2008). Utilization-focused evaluation, 4th edition. Thousand Oaks, CA: Sage.
[10] UFE Checklist, https://wmich.edu/sites/default/files/attachments/u350/2014/UFE_checklist_2013.pdf
[11] CDC Best Practices, p.40, https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf

A. NDQuits annual evaluation

NDQuits, the tobacco cessation quitline for North Dakota, is one component of NDDoH's cessation efforts. Quitlines are an evidence-based practice[12, 13] for increasing cessation efforts, particularly when paired with nicotine replacement therapy (NRT) and health communication efforts. NDQuits has been providing services to North Dakotans since 2004.

PDA has been conducting a formative and summative evaluation of NDQuits since 2011; this longevity has allowed the evaluation to be responsive to ongoing changes to the program. For example, one area of focus in the current evaluation is on the patterns of electronic nicotine devices (ENDS) by North Dakotans calling the quitline. These products are sometimes used by smokers as a perceived method of reducing tobacco use, due to a perceived lower risk. While neither of these are backed by evidence, usage of these products has continued to rise in North Dakota[14], with nearly one in five North Dakotans reporting using of such a device in the past 30 days. This number is rising despite policies such as the use of ENDS being included in North Dakota's smoke-free law[15]. It is imperative that the evaluation continue to monitor trends and report information to NDDoH moving forward.

There are three cessation programs are available to North Dakotans: Quitline only, Web only, or Quitline and web combined. For each program, registrants who are uninsured or underinsured are eligible for up to eight weeks of free nicotine replacement therapy (NRT; combination or mono-therapy) in the form of patches, gum, or lozenges.

NDQuits Evaluation Questions:

i. What is the annual reach of NDQuits?
ii. How do enrollees learn about and connect with NDQuits?
iii. What are the participant characteristics of NDQuits users?
iv. What were patterns of use for NDQuits participants?
v. What were patterns of NRT provision and use?
vi. What are the annual program quit outcomes?
vii. What are the annual patterns of electronic nicotine devices (ENDS) use?
viii. To what extent were participants satisfied with the services received?
ix. What NDQuits program features were associated with quitting overall (after controlling for other factors)?

To answer these questions, PDA uses information collected from quitline registrants at registration (intake data, collected by the quitline vendor) as well as data from a follow-up survey administered to a sample of quitline users (follow-up data collected by PDA's sub-contractor, Wyoming Survey & Analysis Center, WYSAC). Analysis methods implemented by PDA include descriptive statistics, reach calculations,

[12] Best Practices for Comprehensive Tobacco Control Programs – 2014, https://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm
[13] The Community Preventative Services Task Force (Task Force) recommendations for evidence-based tobacco cessation programs, https://www.thecommunityguide.org/content/what-works-boost-tobacco-cessation
[14] Tobacco Surveillance Data May 2018, https://www.ndhealth.gov/tobacco/Data/Tobacco%20Surveillance%20Data%20Table.pdf
[15] Public Health Law Center. E-Cigarette regulations in North Dakota – 2018, http://www.publichealthlawcenter.org/resources/us-e-cigarette-regulations-50-state-review/nd

response bias analysis, and outcomes. To explore the predictors of quitting, PDA conducts a multivariate logistic regression. Full details of these methods are included in PDA's annual reports to NDDoH.

B. Quality Assurance (QA) and data coordination for NDQuits

The evaluation of NDQuits involves data coordination with three vendors. First, the quitline vendor, currently National Jewish Health (NJH), collects intake data from program registrants, as well as utilization data for the web program, the general population telephone program, and the telephone utilization data for two priority populations (pregnant women and American Indians). Second, the counselors for the general population quitline calls are from the counselors at the University of North Dakota's Department of Family and Community Medicine. Third, the quitline vendor provides counseling for registrants who opt-in to the American Indian or the pregnancy protocols. All of the follow-up data is collected by the Wyoming Survey & Analysis Center (WYSAC), a subcontractor of PDA.

Regular (monthly) quality assurance checks are implemented by PDA. When the program or data changes, PDA ensures there is reliable and transparent data available so that NDDoH can understand program intake, utilization, and outcomes for NDQuits, to report to key stakeholders, including the North Dakota Legislature.

NDQuits Quality Assurance Evaluation Questions:

i. To what extent is the intake, utilization, and follow-up data transparent (PDA can understand and use that data for the evaluation)?
ii. What changes have occurred, if any, to the data structure, collected data points, and/or quality for any of the three datasets?
iii. What are the consent rates for the follow-up survey? What factors may be associated with changes in consent rates (e.g., consent language used, using best time to call, etc.)?
iv. What are the patterns of missing data across fields and are there notable gaps in data collection related to program choice, registration month, and/or identifiable participant characteristics?

This information is tracked by PDA, and incorporated, as appropriate, into the annual NDQuits evaluation report that is delivered to NDDoH.

C. *BABY & ME – Tobacco Free™ (BMTF)*

In North Dakota, it is estimated that 16.7% of women who gave birth in 2016 smoked within three months of becoming pregnant[16]. The health risks to the mother and fetus compound the negative economic impact, with estimates by the CDC that there is an increase of approximately $700.00 of smoking-attributable neonatal expenditures per maternal smoker[17]. As a response NDDoH has been implementing the BMTF program to support cessation for pregnant mothers for the past decade.

[16] North Dakota Vital Statistics, 2016. Data pulled by Carmell R. Barth. Accessed March 27, 2018.
[17] CDC. State Estimates of Neonatal Health-Care Costs Associated with Maternal Smoking --- United States, 1996. *Morbidity and Mortality Weekly Report*. 2004;53((39)):915-917.

PDA has been conducting evaluation of the BMTF program for the past few years. The evaluation questions include both process questions as well as inquiry into program outcomes. Similar to the NDQuits evaluation, prior evaluation efforts have informed and have been responsive to programmatic changes. For example, in FY18, PDA started to incorporate program outcomes for birth weight. A new exploration that will be reported on in FY19 is the impact of the dedicated counselor model on program outcomes.

BMTF Evaluation Questions:

i. What are the participant characteristics for BMTF?
ii. What proportion of women who attend the BMTF program prenatal counseling sessions are also referred to NDQuits?
iii. What is the nature of BMTF program use (overall minutes of counseling, prenatal participation patterns, postpartum participation & graduation patterns)?
iv. Program outcomes
    a. What are cessation patterns through the prenatal counseling sessions?
    b. What are cessation patterns postpartum?
    c. What are birth weight outcomes?
    d. What are the gestational age outcomes?
v. How is the BMTF program adapted to the local context in North Dakota?
vi. What is the relationship between the dedicated counselor model and program outcomes (FY19 only)?

Evidence to address these evaluation questions include the quarterly data reported by BMTF grantees, including participant registration and program use (prenatal and postpartum). In addition, PDA uses surveillance (vital statistics) and supplemental program documentation (quarterly calls with the national BMTF founder, success stories, narrative reporting on successes and challenges).

Analysis includes descriptive statistics and narrative descriptions. Further, PDA calculates an Intention to treat (ITT), which is an approach to analysis that allows comparisons between groups where dropout may otherwise lead to biased results. No one is excluded from analysis who has had enough time to achieve each outcome. In the BMTF analysis, this method is used for calculation of abstinence rates at each program visit. Operationally, this means it is assumed anyone who did not return to a session, but should have, is still using tobacco and is kept in the analysis. This is done in order to avoid inflation of the abstinence rates observed at each time point.

Results are reported annually in a report delivered to NDDoH.

D*. NDQuits Cessation (NDQC) Grantees*

A recommended national clinical guideline to address tobacco cessation at the systems level, specifically in clinical settings, is the 5 A's approach (Ask, Advise, Assess, Assist, and Arrange)[18]. Interventions which

[18] US Public Health Service Report. (2008). A clinical practice guideline for treating tobacco use and dependence: 2008 update. *American Journal of Preventative Medicine 35*(2), 158-176.

include the 5 A's, even interventions as brief as three minutes, have been shown to increase cessation rates significantly[19], and in a cost-effective manner[20].

Since 2012, the North Dakota Department of Health (NDDoH) Tobacco Prevention and Control Program has funded North Dakota health systems via the NDQuits Cessation (NDQC) Core Grant Program (previously known as Million Hearts® Grants). The focus of this program is to advance tobacco treatment efforts in North Dakota's healthcare systems.

In FY18 NDDoH has funded ten grantees to implement tobacco treatment in healthcare systems, including addiction facilities. The NDQC grantees provide inpatient and/or outpatient tobacco treatment to patients and also refer individuals to NDQuits. Each grantee maintains at least one Tobacco Treatment Specialist (TTS). Counseling using the 5 A's approach is implemented (Ask, Advise, Assess, Assist, and Arrange), as is pharmacotherapy, as appropriate.

PDA has been conducting a process evaluation of these efforts since FY15. Following the FY17 report, PDA identified data limitations and proposed to revise the quarterly data collection process, including the questions asked. Interviews were conducted with each of the NDQC grantees, and revisions to the quarterly data collection tool were made, incorporating review by NDDoH and feedback from the grantees. The goals of this revision were to improve data quality, and to account for and document the context-specific successes and challenges of the grantees, who represent a variety of health systems, from large, multi-state systems to rural systems that span a large geography.

NDQC Evaluation Questions

i. What is the approach of each grantee to implement tobacco cessation services in their healthcare systems? What are the unique approaches and/or contexts across grantees?
ii. To what extent have NDQC grantees established or maintained a Tobacco Cessation Center in-house with trained TTS? How many TTS have been trained over the fiscal year?
iii. Program Utilization:
    a. How many total TTS visits occur over the fiscal year, across grantees?
    b. To what extent are patients receiving bridge nicotine replacement therapy (NRT)?
    c. To what extent are patients referred to NDQuits?
iv. What types of educational trainings are taking place to train TTS? How many events occurred? How many attended events over the fiscal year?
v. What are the challenges and successes of using electronic medical records to track data related to the NDQC efforts?
vi. What key measures are the grantees opting to track? What are the results of these efforts?

[19] Fiore, M.C., Jaén, C.R., Baker, T.B., Bailey, W.C., et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline.* Rockville, MD: U.S. Department of Health and Human Services.
[20] West, R., Raw, M., McNeill, A., Stead, L., Aveyard, P., Bitton, J., . . . Borland, R. (2015). Health-care interventions to promote and assist tobacco cessation: A review of efficacy, effectiveness and affordability for use in national guideline development. *Addiction, 110*(9), 1388-1403.

Evidence to address these evaluation questions primarily include an annual planning document, and quarterly reports that track progress toward grant-related work. These reports include both quantitative and qualitive reporting. PDA will prepare and deliver an annual process report on NDQC grantee activities on an annual basis. In addition to an annual process report, PDA conducts analysis quarterly and provides each NDQC grantee with a quarterly dashboard.

❷ State and Community Interventions

A key component of a strong tobacco control program is grassroots or locally-led efforts in the areas of tobacco prevention, cessation, and social norms change. In North Dakota, 28 LPHUs are provided funding to implement these efforts. In addition, NDDoH funds several tribal grantees to lead similar efforts in tribal areas. Finally, various supportive organizations are funded through special initiative grants relating directly to priority elements in the State Plan, including TFND and PETF.

State and community efforts have been found to be most effective when there is a coordinated, synergistic effort between the state and local levels to advance policies, to educate on the dangers of tobacco and available cessation resources, to prevent initiation of tobacco use, and to affect social norms[21]. In particular, community efforts are often more able to be responsive and representative of localized needs and context and with state support should also aim to address health disparities. Principles of community engagement can guide these efforts[22]. The overall guiding evaluation question for this component is: *To what extent is North Dakota implementing coordinated and combined state and community efforts to implement policies, partnerships, and interventions that promote cessation, prevention, and social norms change?*

The guiding evaluation questions for each of the state and community interventions are as such:

A. Local Public Health Units (LPHUs)

The 28 LPHUs work on the four goals for the State Plan: (1) preventing initiation of use in youth and young adults; (2) eliminating exposure to SHS; (3) promotion of cessation with youth and adults; and (4) building capacity and infrastructure to implement a comprehensive tobacco control program. Key efforts identified in the State Plan include increasing the prince of tobacco products; implementing tobacco-free policies in K-12 local education agencies (LEA), in colleges and universities, and in multi-unit housing (MUH) across the state; addressing and reducing disparities in tobacco use and harm; and building state and local coalitions and partnerships.

The evaluation of this work is both formative and summative; quarterly report dashboards will be created and shared with each of the grantees so they can understand how their work relates to and contributes to the statewide progress on the tobacco plan.

[21] Zaza S, Briss PA, Harris KW, editors. The Guide to Community Preventive Services: What Works to Promote Health? New York: Oxford University Press, 2005.

[22] U.S. Department of Health and Human Services. Principles of Community Engagement: Second Edition. National Institutes of Health, Centers for Disease Control and Prevention, and Agency for Toxic Substances and Disease Registry, 2011. NIH Publication No. 11-7782.

LPHU Evaluation Questions

i. What is the collective effort of the LPHUs in working toward the goals and objectives set forth in the North Dakota State Tobacco Plan?
   a. To what extent have grantees worked with LEAs to adopt a comprehensive model tobacco-free school policy?
   b. To what extent have grantees worked with post-secondary institutions to adopt tobacco-free campus policies?
   c. To what extent have grantees engaged youth in tobacco prevention initiatives?
   d. How have grantees provided education and prevention efforts focused on ENDs?
   e. To what extent have grantees coordinated with ND DHS to promote and implement the Synar State Tobacco Compliance Check Program?

ii. What are key success stories from the work at the local levels?

iii. To what extent are key priority populations effectively reached by grantees? In what ways are these key populations being engaged?

iv. What are the key barriers with the work at the local levels?

v. How is capacity being built across the state among community interventions, to promote collaboration, sharing, and shared learning?
   a. Workgroups (Coalition, Policy, Communication, Evaluation, Cessation, Youth)
   b. CDC Best Practices Training
   c. TFND
   d. Quarterly, in-person meetings

Evidence to address these questions include data collected in the quarterly reports, which include both quantitative and open-ended responses around successes, challenges, and lessons learned. PDA will provide NDDoH and individual LPHUs with quarterly dashboard reports that display progress toward the State Plan's four goals. In addition, PDA will prepare an annual report that will be delivered to NDDoH.

B. Tribal grantees

In North Dakota, American Indians have a notably higher rate of tobacco use than the general population, with nearly half reporting using tobacco in the past 30 days in 2016, as compared to one in five adults from the general population.[23] North Dakota has four federally-recognized Tribal Nations: Spirit Lake Sioux Tribe, Standing Rock Sioux Tribe, Three Affiliated Tribes, and Turtle Mountain Band of Chippewa. Since 2008, NDDoH has funded tribes directly to implement CDC's Best Practices in Tobacco Prevention and Cessation[24]. Each funded tribe has a dedicated Tribal Tobacco Prevention Coordinator (TTPC) that leads and coordinates these efforts.

Similar to the LPHUs, the evaluation of the work led by the tribal grantees will be formative and summative in nature, with a particular focus on how these efforts contribute to the broader statewide tobacco plan.

[23] https://www.ndhealth.gov/tobacco/Data/Tobacco%20Surveillance%20Data%20Table.pdf
[24] http://www.astho.org/Prevention/Tobacco/North-Dakota-Engages-American-Indian-Tribes-in-Tobacco-Prevention/

Tribal Grantees Evaluation Questions

i. What is the collective effort of the tribal grantees in working toward the goals and objectives set forth in the North Dakota State Tobacco Plan?
ii. What are key success stories from the tribal work?
iii. What are the key barriers experienced by the tribal grantees?

Evidence to inform these questions include quarterly reports submitted to NDDoH. PDA will also conduct informal interviews with NDDoH's Health Communications and Equity Specialist and the tribal liaison to document state-level training, technical assistance, and participation in the Inter-Tribal Tobacco Abuse Coalition (ITTAC). Results will be incorporated into the synthesized report delivered to NDDoH.

C. Legislative Efforts

The American Lung Association gave North Dakota a "F" grade in the area of tobacco taxes[25]. As a state with one of the lowest costs of tobacco in the United States, there is an economic impact. Higher tobacco prices deter youth initiation of tobacco use and may help motivate current smokers to seek cessation support. The primary legislative effort for the biennium is to move forward a proposal to increase the price of tobacco. These efforts are referred to as "Project 19."

Another policy effort that may be explored is an effort to educate on the potential benefits of increasing the price of tobacco to 21. As a point of reference, some exploration and work was done by Tobacco 21 (Eric Brodell, Wester Region Director, Tobacco 21) and Tobacco Free Kids (Jodi Radke, Rocky Mountain/Great Plains Region, Tobacco Free Kids) in this area in early 2017 but it did not move forward in the Legislature (House Bill 1312 was introduced but it did not pass the House floor reading). This is a secondary policy effort, with the primary focus for the biennium on increasing price with the Project 19 efforts.

The Public Health Law Center will write legislation for Project 19, with a goal of having that completed by the end of summer 2018. Partners such as Tobacco Free North Dakota (TFND) and the Public Education Task Force (PETF) will be instrumental in advocacy and education efforts related to Project 19. PDA will track efforts around Project 19 on the LPHU quarterly reporting forms, in tracking of legislative efforts, and in conversations with NDDoH. Findings will be incorporated into PDA's synthesized report of all tobacco control activities.

3 Health Communication Interventions

A strong, state-level health communications intervention is essential to affect cessation, prevention, and social norms change. The media methods implemented should include wide-reaching broadcast media (television and radio ads), as well as social media, earned media, billboards, press releases, conferences, and health promotion activities. Evaluative information will be collected by various entities, including the media vendor, the LPHUs, NDDoH, and PDA.

[25] http://www.lung.org/our-initiatives/tobacco/reports-resources/sotc/state-grades/

The closing of The Center and reduction of the funding to tobacco control in the state by $3.2 million had a notable effect on the resources available for the media, particularly the broadcast media efforts that are particularly essential for promotion of cessation resources, such as NDQuits, as well as social norms change, prevention, and educational efforts. In this evaluation we plan to spend the first year of the biennium exploring and documenting the changed landscape and strategic priorities of the health communication efforts. This is particularly important as efforts are implemented by many diverse groups (e.g., the media vendor, LPHUs, PETF, TFND, etc.). In FY19, PDA will design the evaluation to grow these strategic priorities.

Health Communications Evaluation Questions:

i. What media efforts have been undertaken across platforms and how do they align with CDC Best Practices in Tobacco Control?
ii. What are the health communications priorities for the biennium, particularly considering the more limited resources available for these efforts?
iii. How are health communications resources optimized given limited funding?
iv. What are the successes and barriers around health communications?
v. Is there evidence of the media campaign for cessation influencing the number of NDQuits participants?

PDA will conduct an interview study in FY18 with key partners involved in health communications efforts, including: Odney (media vendor), PETF, TFND, and NDDoH. A report will be delivered to NDDoH at the end of FY18. Odney will take the lead in collecting quantitative data related to media campaigns, including digital flights, Facebook analytics, and other indicators. PDA will incorporate findings into the synthesized report. Based on the findings of the FY18 interview study, PDA will define the FY19 evaluation around heath communications. Results will be synthesized into the synthesized report for the North Dakota Legislature, and may be related to ad hoc reports for NDDoH.

❹ Surveillance and Evaluation

The focus of a strong surveillance and evaluation plan is having a process in place to monitor trends around attitude, behaviors, and outcomes related to tobacco in the state over time. The primary purpose of such a system is to demonstrate accountability and program effectiveness. At the start of the biennium, NDDoH has strong surveillance in place, with systems already set up to provide public-facing documents that show trends in tobacco use, tobacco use initiation, tobacco consumption, cessation, tobacco-related policy, and economic indicators around tobacco[26]. A primary evaluation goal for this biennium is to build more efficiently and effectively the surveillance into this comprehensive evaluation work, particularly since PDA will be able to build upon the surveillance capacity at NDDoH.

[26] Tobacco Surveillance Data, January 2018, https://www.ndhealth.gov/tobacco/Data/Tobacco%20Surveillance%20Data%20Table.pdf

Surveillance and Evaluation Guiding Questions:

i. What are the data and information gaps, particularly in relation to monitoring progress on the North Dakota State Tobacco Plan?
ii. To what extent are surveillance and evaluation efforts coordinated to effectively and efficiently meet the needs of the primary intended users?
iii. To what extent have surveillance and evaluation activities been integrated into programmatic and strategic activities? To what extent is evaluation responsive to the changing needs of the programmatic and strategic work in the state?
iv. To what extent are the following trends monitored? To what extent is the following information made available for public use?
    a. Preventing initiation among youth and young adults
    b. Trends in promoting quitting
    c. Trends in exposure to secondhand smoke
    d. Economic impact of tobacco
    e. Tobacco-related disparities among key priority groups
v. What additional data collection systems or approaches are needed to adequately capture the outcomes of key priority groups (American Indians, lesbian, gay, bisexual, transgender, queer (LGBTQ), pregnant women, residents served by Medicaid, and smokeless tobacco users)?

Surveillance data will be incorporated into many of the evaluation's sub-components (e.g., using vital statistics for the BMTF analysis and report).

5 Infrastructure, Administration, and Management

This component of an effective tobacco control program centers around having adequate resources to provide program oversight, training, and technical assistance. This includes funding, staff knowledge and skills, and other resources related to program sustainability. The CDC Guide for Best Practices in Tobacco Control uses the Component Model of Infrastructure (CMI) to visualize and make explicit the backbone components of effective infrastructure[27]. This model includes five core components: networked partnerships, multilevel leadership, engaged data, managed resources, and responsive plans/planning.

Evaluation Questions about TPCP Infrastructure, Administration, and Management:

i. To what extent did NDDoH engage in strategic planning work following the legislative changes and reduction of funding to tobacco control starting in FY18? What was the nature of strategic planning efforts? What are the key lessons learned?
ii. To what extent is tobacco control integrated into various chronic disease initiatives at the state? At the local levels? At the national level (e.g., NACDD)?
iii. To what extent does NDDoH increase capacity at the local level to engage in tobacco control efforts? What are the successes and barriers of these efforts?
iv. To what extent does NDDoH engage in strategic planning efforts around tobacco control?
v. What is the result of a coordinated tobacco prevention and cessation effort? What is the value to the state as a result of this coordination?

[27] CMI, page 65, https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf

Evidence to address these questions include site visits and attendance (in person or virtual) in the quarterly partners meetings; review of white papers and other technical documents produced by NDDoH and partners; and synthesis of the five components of tobacco control.

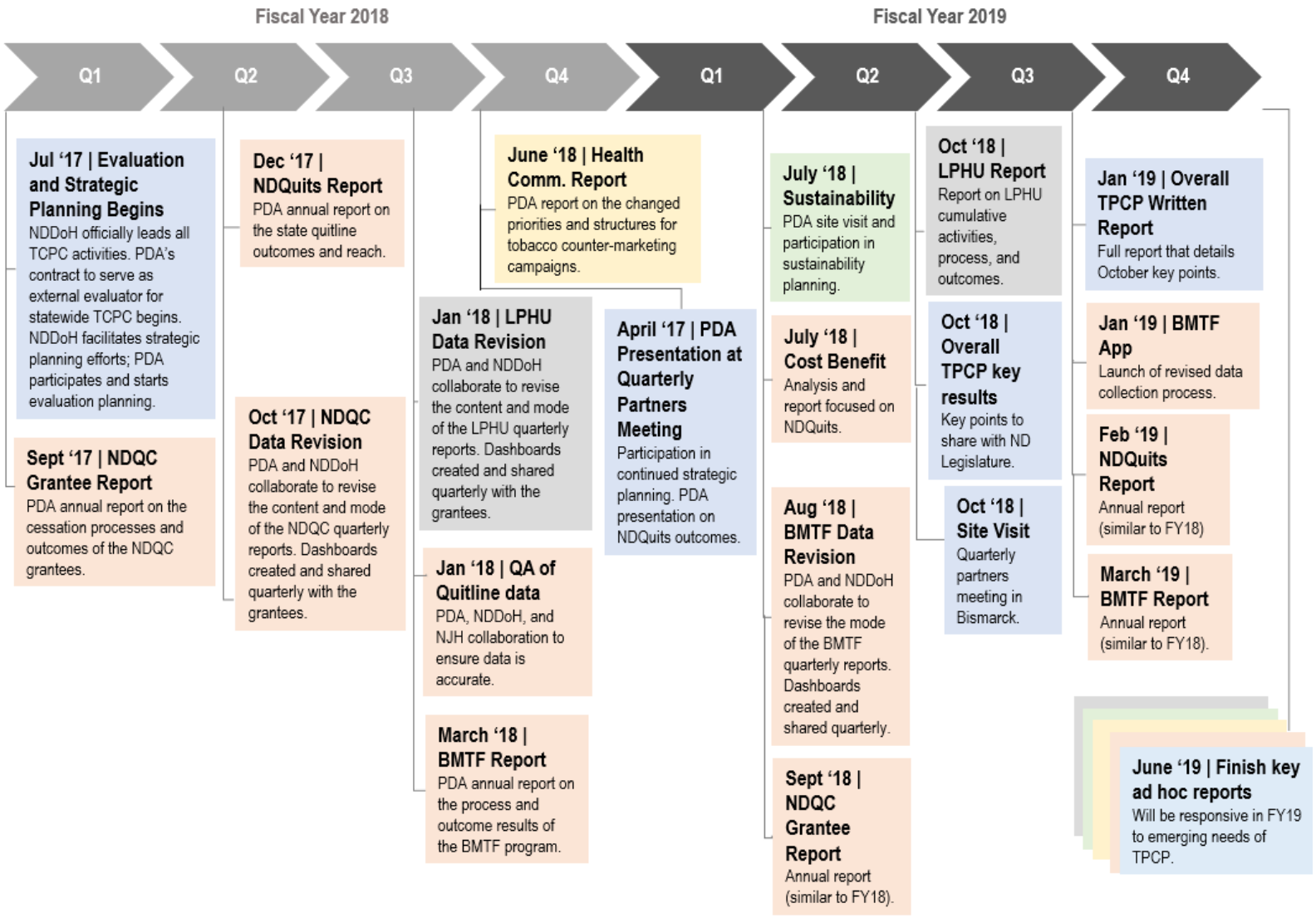
Deliverables

PDA will engage in regular communications with NDDoH about the timing and nature of the evaluation deliverables. One of PDA's major deliverables will be related to strategy 4.4.7 in the State Plan: an independent review of the North Dakota State Comprehensive Tobacco Prevention and Control Plan and present to the North Dakota Legislative Management during the 2017 – 2019 biennium. PDA will provide NDDoH with top level evaluation findings as speaking points by October 2018. A comprehensive written report will be finalized and submitted to NDDoH by early January 2019.

Other major deliverables include:

- This document – A comprehensive evaluation plan to guide the evaluation priorities for the biennium, including a review of surveillance and previously constructed logic models.
- Conduct two annual site visits
- Annual evaluation reports that review activities, processes, and outcomes for the following initiatives:
    - NDQuits use, reach, and outcomes (quitline and web program)
    - NDQC Grantee Program (health systems)
    - LPHU's cumulative work toward the State Plan
    - BMTF Program
- Quarterly reporting for the following
    - LPHUs
    - NDQC Program
    - BMTF Program
    - Tribal Tobacco Prevention Coordinators (only as-needed)
- Health communications (process evaluation + report in FY18, define in FY19)
- Cost benefit analysis for NDQuits
- Ad hoc reports and evaluation-related information requests in FY19, to be responsive to the needs of multiple stakeholders, including NDDoH and the North Dakota Legislature.

North Dakota TPCP Timeline of Evaluation Activities for Biennium



Appendices

A. Logic model template
B. Surveillance related to tobacco control in North Dakota
C. North Dakota State Comprehensive Tobacco Prevention and Control Plan 2017 – 2019
D. Evaluation Methodology Tables

Appendix A. Logic Model

PDA plans to use guidance of the Centers for Disease Control's Office of Smoking and Health (CDC OSH) and best practices in evaluation research to develop responsive and useful logic models in FY19. This was started but not completed in FY18 since the structure of tobacco prevention and control was emerging following the de-funding of the Center.

The framework for this emerging model is presented below and will be revised as the coordinated statewide work continues to move forward.

Key Partnerships	Leadership, Technical Assistance, and Statewide Coordination	NORTH DAKOTA DEPARTMENT of HEALTH
	Education, Advocacy, and Policy Efforts	Tobacco Free North Dakota; PUBLIC HEALTH LAW CENTER, Tobacco Control Legal Consortium
	Implementation of efforts in prevention, cessation, local coalitions, and communications	BreatheND, Local Public Health Working For You.; Public Health; Odney Smart
	Evaluation and Research	PDA; AMERICAN CANCER SOCIETY; Campaign for Tobacco-Free Kids; American Heart Association.; AMERICAN LUNG ASSOCIATION.
Driving Activities	NDQuits, BMTF, NDQC	1 Cessation Interventions
	LPHU & Tribal Grantees	2 State and Community Interventions
	BreatheND and Cessation efforts	3 Health Communication Interventions
	Formative and Summative	4 Surveillance and Evaluation
	Coordination and Capacity	5 Infrastructure, Administration, & Management
Desired Outcomes	Prevention of Tobacco Use	Increase price of tobacco, implement effective school and college tobacco use policies, mobilize to restrict minor's access to tobacco products
	Eliminate SHS Exposure	Maintain comprehensive smoke-free laws, prevent preemption, increase policies addressing smoke-free MUH, increase number of outdoor smoke-free policies
	Promote Cessation	Increase the annual treatment reach of NDQuits, increase the number of healthcare settings assessed that use the systems approach for tobacco dependence treatment.
	Build Capacity & Infrastructure	Maintain administrative structure to manage the ND TPCP in concurrence with CDC Best Practices for TPCP.

Appendix B. Surveillance Data Sources

A key component of evaluation efforts are to track long-term trends in smoking use, initiation, economic impacts, and other outcomes. PDA will continue to coordinate with the Lead Chronic Disease Epidemiologist at NDDoH (Clint Boots) to ensure this data is being tracked and utilized toward monitoring the impact of TPCP efforts. This table summarizes surveillance instruments considered and used.

Data Source	How to access data?	Summary of demographic questions	Summary of tobacco user questions	Summary of other tobacco modules or other data points of interest	Frequency of administration
Behavioral Risk Factor Surveillance Survey (BRFSS)	Online through CDC website.	Gender; Age; Education level; Race; Hispanic or Latino ethnicity; number of children in HH; Pregnant; General health; Mental health; Physical health Indian Health (Tribal affiliation, insurance) Methods of coping with stress (social context)	**Current tobacco use** (cigarette, smokeless tobacco (SLT), e-cigarette, frequency of use); **Quit attempts** (stopped smoking in past 12 months, interval since last smoked)	None to report	Annually (most recent is 2016)
Youth Risk Behavioral Surveillance Survey (YRBSS)	North Dakota Department of Public Instruction	Gender Age Education level Race Hispanic or Latino ethnicity Pregnant Sexual orientation	**Current tobacco use** (cigarettes, SLT, cigar/cigarillo, e-cigarette, frequency of use); **Age of initiation** (first tried, first smoked whole)	****How accessed tobacco** (e-cigarette, cigarette)	Biennially (most recent is 2017)
ND Adult Tobacco Survey (ND-ATS)	NDDoH TPCP	Sexual orientation; Health insurance type; General health; Physical health; Mental health; Household income; Marital status; Ethnicity/Race; Education; Gender; Employment; Housing Type'	**Current tobacco use **Cigarette Specific **Stage of readiness **Age of initiation **Intention to quit tobacco	**Intention to try tobacco products **Harm switches **Media influence **Health beliefs about tobacco **Cost data **Secondhand Smoke Exposure **Social norms of tobacco use	Planned to be biennial going forward (most recent is 2017)

Data Source	How to access data?	Summary of demographic questions	Summary of tobacco user questions	Summary of other tobacco modules or other data points of interest	Frequency of administration
ND Youth Tobacco Survey (ND-YTS)	NDDoH - TPCP	Age Gender Hispanic or Latino ethnicity Race Disposable income	**Current tobacco use (cigarette, cigar/cigarillos, slt, pipe, Bidis, other, e-cigarette, more than one type, frequency of use); **Cigarette Specific (cig per day, time to first, age started smoking); **Stage of readiness; **Age of initiation (first tried cigarette, cigar, SLT); **Intention to quit tobacco (for good, plan to quit in next XX days, ever attempted to quit tobacco, last quit attempt, quit assistance)	**Beliefs about tobacco companies **SHS Exposure **Social norms of tobacco use **Health beliefs about tobacco **Social beliefs about tobacco **Community influence **Media influence **Health provider influence **How accessed tobacco	Biennially (most recent is 2017)
American Indian Adult Tobacco Survey (AI-ATS)	Data remains with the tribes			Interested in getting a more accurate estimate of tobacco use among the tribes. Need a survey that has enough cases to power AI analysis.	Last administered in 2008; next administration to be determined
Pregnancy Risk Assessment Monitoring System (PRAMS)	NDDoH - TPCP	Annual income 12 months before baby was born Father and Mother race/ethnicity Father education Mother: Age, marital status, education, and place of birth	Cigarettes per day (CPD) before, during, and after pregnancy CPD at time of survey E-cigarette use before/during pregnancy E-cigarette/Hookah use in past 2 years	No additional modules in overall PRAMS questionnaires (but states can add state-specific questions)	Annually (But ND Data limited)-Most recent ND is 2002

Data Source	How to access data?	Summary of demographic questions	Summary of tobacco user questions	Summary of other tobacco modules or other data points of interest	Frequency of administration
American Community Survey (ACS)	Online, Census website	Population estimates for… Total population; Age groups; Sex; Race; Ethnicity; Education; Citizenship; Language; Marital status/history; Veteran status; Place of birth; Employment; Income	None to report- use census for population estimates only	None to report- use census for population estimates only	Annually-Most recent is 2016
Census	Available online through the Census website	Total population %population under 18 race gender age	None to report- use census for population estimates only	None to report- use census for population estimates only	Annually
Current Population Survey- Tobacco Use Supplement CPS-TUS	Online through the CPS-TUS website	Age Gender Marital status Hispanic or Latino ethnicity Race Income Education level Country of birth Citizenship Employment status	**Current smoking status and CPD **use of menthol cigarettes **level of nicotine dependence (time to first cig) **Use of other tobacco products, and use of flavored tobacco products **smoking history (age became regular smoker), quit attempts and intention to quit	**cost of cigarettes (and coupon use) and purchase location and type (single vs carton vs pack) **medical/dental advice to quit **cigar, pipe, and smokeless tobacco use; **harm reduction and other emerging products **workplace and home smoking restrictions **attitudes toward smoke-free policies in public places. **attitudes towards smoking in multi-unit housing	Every 3-4 Years- Most recent is 2014-15

Data Source	How to access data?	Summary of demographic questions	Summary of tobacco user questions	Summary of other tobacco modules or other data points of interest	Frequency of administration
School Health Policies and Practices Study (SHPPS)	Available through North Dakota Department of Public Instruction	None to report	None to report	**Policy for students **Policy for teachers **Policy for visitors to school property (types of tobacco, location of bans)	Unknown
ND Tobacco Surveillance Data	NDDoH - TPCP	n/a	Tobacco prevalence from BRFSS	Tobacco use initiation; tobacco consumption; cessation; tobacco-related policy; tobacco-related health and economic consequences from a myriad of sources.	Last updated Jan. of 2018
Campaign for Tobacco Free Kids (CTFK)	Online through the Campaign for Tobacco Free Kids website	n/a	None to report	Range of deaths due to secondhand smoke exposure; smoking attributable medical expenditures; smoking attributable productivity costs	
North Dakota Vital Statistics	North Dakota Vital Records Division or NDDoH - TPCP	n/a	Tobacco prevalence among women who gave birth in ND	None to report	Ongoing; previous year's rate released annually in August
North Dakota Tax Department Office of State Tax Commissioner Statement of Collections	Unsure	n/a	None to report	Annual number of cigarettes sold and annual cigarette and other tobacco product tax revenue collected.	Annual- most recent is 2017

Data Source	How to access data?	Summary of demographic questions	Summary of tobacco user questions	Summary of other tobacco modules or other data points of interest	Frequency of administration
National Survey on Drug Use and Health (NSDUH)	SAMHSA	n/a	Past month tobacco use prevalence for ND by age group Past month cigarette use prevalence for ND by age group	None to report	Annual- most recent is 2015-16, data for ND from 14-15
CORE Alcohol and Drug Use Survey	Summary report available online	n/a		Tobacco use among college students.	
Federal Trade Commission Report	Online through the Trade Commission	n/a		Tobacco industry marketing in ND	Most recent was 2013
Smoking-Attributable Morbidity, Mortality and Economic costs (SAMMEC)	Available online through the CDC	n/a		economic costs of smoking including low productivity	
Question Inventory on Tobacco (QIT)	Available online through the CDC	n/a	Too many to list - compilation	This is a database of all tobacco related questions from CDC and Office on Smoking and Health (OSH) surveys. The question, year administered, and survey source are the primary fields.	ongoing
Secretary of State		n/a		Number of registered lobbyists lobbying for tobacco company interests	ongoing
Secretary of Treasury		n/a		Distribution of cigarette taxes to municipalities	ongoing

Appendix C. State Plan

North Dakota Comprehensive Tobacco Prevention And Control State Plan 2017

Tobacco use is the single most preventable cause of death and disease in North Dakota and the United States, causing more deaths annually than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides, combined.

The current North Dakota Comprehensive Tobacco Prevention and Control State Plan (State Plan) is a state plan coordinated by the North Dakota Department of Health (NDDoH) Tobacco Prevention and Control Program (TPCP). TPCP seeks the input and collaboration of many partners, from state agencies to grassroots community organizations working together in implementing this plan to reduce North Dakota's burden from tobacco.

MISSION

The mission of the TPCP is to improve and protect the health of North Dakotans by reducing the negative health and economic consequences of the state's number-one cause of preventable disease and death - tobacco use.

GOAL

The goal of the TPCP is to reduce disease, disability, and death related to tobacco use by:

- Preventing initiation among youth and young adults
- Promoting quitting among adults and youth
- Eliminating exposure to secondhand smoke
- Identifying and eliminating tobacco-related disparities among specific population groups

Through this State Plan, the TPCP implements a process-based and outcomes-based evaluation of programs to keep state government officials, policymakers, and the public informed. The TCPC recognizes that monitoring and evaluating the planning activities and status of implementation is as important as identifying strategic issues and action steps. The State Plan is intended to be dynamic and will be updated as progress is made, or change is indicated. Regularly scheduled meetings will occur so that the TCPC, its advisory body, and partners can clarify and analyze progress, issues, challenges, and lessons learned. This will allow TCPC the opportunity to change recommendations, plans, and resources as required and continuously evaluate progress and outcomes.

MODEL FOR COMPREHENSIVE TOBACCO PREVENTION AND CESSATION

The State Plan for comprehensive tobacco prevention and cessation is based on *Best Practices for Comprehensive Tobacco Control Programs* (Best Practices) model outlined by National Centers for Disease Control and Prevention (CDC). Best Practices describes an integrated programmatic structure for implementing interventions proven to be effective. The model also relies on *The Guide to Community Preventive Services for Tobacco Control Programs* (Community Guide), which provides evidence on the effectiveness of community-based tobacco interventions within three areas of tobacco use prevention and control:

- Preventing tobacco product use initiation
- Increasing cessation
- Reducing exposure to secondhand smoke

In addition to the Community Guide, the 2008 *Update of the Clinical Practice Guideline for Treating Tobacco Use and Dependence* has shaped the tobacco control interventions being implemented in North Dakota.

The TPCP continues to incorporate the program elements recommended by the CDC. It is important to recognize that these individual components must work together to produce the synergistic effects of a comprehensive tobacco control program, which includes:

- Community based programs
- Cessation interventions, including NDQuits, North Dakota's telephone and web-based tobacco cessation service
- Statewide public education campaign
- Evaluation and surveillance
- Infrastructure, administration, and management

JUSTIFICATION FOR FOCUSING ON GOAL AREAS

The State Plan goal areas, based on Best Practices and Community Guide recommendations, also include crosscutting interventions based on recommendations from these sources.

Prevent Initiation of Tobacco Use Among Youth and Young Adults

Increase the unit price of tobacco products.

Rationale: Projections of research findings from the Campaign for Tobacco-Free Kids' indicate that each 10 percent cigarette price increase reduces youth smoking by 6.5 percent, adult smoking rates by 2 percent, and total consumption by about 4 percent (adjust down to account for tax evasion effects). *The Guide to Community Preventive Services*, November 2012, pages 1-2 confirms, "public health effects are proportional to the size of price increase and scale of intervention." CDC Best Practice for Comprehensive Tobacco Control Programs January 2014 recommends an increase of the unit price of tobacco products for preventing tobacco use among youth.

Implement effective school and college tobacco use polices throughout North Dakota.

Rationale: "Community programs and school and college policies and interventions should be part of a comprehensive effort, coordinated and implemented in conjunction with efforts to create tobacco-free social norms, including increasing the unit price of tobacco products, sustaining anti-tobacco media campaigns, and making environments smoke-free." (*Best Practices for Comprehensive Tobacco Control Programs*, January 2014, page 19). A tobacco-free school policy promotes a tobacco-free lifestyle and environment for all students, staff, and visitors as well as establishes a tobacco-free social norm.

Mobilize the community to restrict minors' access to tobacco products, in combination with additional interventions (stronger local laws directed at retailers, active enforcement of retailer sales laws, and retailer education with reinforcement).

Rationale: In the 2012 Surgeon General's Report on Preventing Tobacco Use Among Youth and Young Adults, "Prevention efforts must focus on both adolescents and young adults because among adults who become daily smokers, nearly all first use of cigarettes occurs by 18 years of age (88 percent) with 99 percent of first use by 26 years of age. Advertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking and other tobacco products use among adolescents and young adults" (page 8). The tobacco industry's own internal correspondence and testimony in court, as well as widely accepted principles of advertising and marketing, support the conclusion that tobacco advertising recruits new users as youth and reinforces continued use among young adults (page 522). Emerging and traditional tobacco products are the instruments for recruitment.

Eliminate Exposure to Secondhand Smoke

Maintain comprehensive smoke-free laws in North Dakota.

Rationale: In November 2012, North Dakota passed one of the strongest laws in the United States to protect all citizens from secondhand smoke and prevent youth initiation use of tobacco products. Secondhand smoke is a mixture of over 7,000 chemicals, which contaminates both indoor and outdoor air. Exposure to secondhand smoke may lead to adverse health effects to all exposed, especially children. Some

adverse health effects experienced by children are middle ear disease, respiratory symptoms, impaired lung function, asthma, pneumonia, and sudden infant death syndrome. These symptoms and diseases have been causally linked to secondhand smoke. Adults exposed to secondhand smoke also have causally linked evidence from nasal irritation to lung cancer, coronary heart disease, and reproductive effects in women, i.e. low birth weight of infants. Chronic diseases caused by smoking are clearly articulated in the U.S. Surgeon General's Report in *How Tobacco Smoke Causes Disease*, (2010, page iii). There is no safe level of exposure to cigarette smoke.

Prevent preemption in all North Dakota state tobacco prevention and control laws.

Rationale: "Preemption can eliminate the benefits of state and local policy initiatives. Preemption can also have a negative impact on enforcement, civic engagement, and grassroots movement building." (Pertschuk, Pomeranz, Aoki, Larkin, Paloma (June 15, 2012). Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers. *Journal of Public Health Management Practice*, https://www.ncbi.nlm.nih.gov/pubmed/22759986)

Increase the number of policies addressing smoke-free multi-unit housing and work places not protected under the current smoke-free law in North Dakota.

Rationale: Secondhand smoke is a well-established risk factor for morbidity and mortality due to the hundreds of toxic carcinogens found in secondhand smoke. Twenty three percent of North Dakota's population, or approximately 152,000 people, reside in multi-unit housing. North Dakota's smoke-free air law protects persons at work and in other public places. However, multi-unit housing still represents a major source of secondhand smoke exposure due to transfer of secondhand smoke through shared walls, hallways, ventilation systems, electrical lines, and plumbing systems. Exposure in multi-unit housing can be as high as 65 percent when air comes from other units via ventilation and smoke drift. Drifting smoke is a commonly reported complaint in multi-unit housing. Smoke-free and tobacco-free multi-unit housing benefits include decreased apartment cleaning costs, fire risks and liability, and increased marketability.

Increase the number of smoke-free policies in outdoor areas not protected under current smoke-free law in North Dakota.

Rationale: North Dakota's smoke-free air law covers indoor spaces; consequently, many citizens may be exposed to secondhand smoke and the resultant toxins at outdoor venues. Outdoor venues that are smoke-free and tobacco-free promote healthy, active living, and a tobacco-free lifestyle, providing a great example for children and youth. Tobacco-

free outdoor areas reduce environmental clean-up cost, potential fire concern, and toxic waste exposure for children and animals. Local control for smoke-free and tobacco-free outdoor venues give communities the solutions that address specific local concerns.

Promote Quitting Tobacco Use

Increase the annual treatment reach of NDQuits to all North Dakota cigarette smokers.

Rationale: *The Community Guide* from Community Preventive Services Task Force (August 2012) recommends "three interventions effective at increasing use of quit lines: mass-reach health communications interventions that combine cessation messages with a quit line number; provision of free evidence-based tobacco cessation medications for quitline clients interested in quitting; and quitline referral interventions for health care systems and providers. Evidence also indicates a quitline can help to expand the use of evidence-based services by tobacco users in populations that historically have had the most limited access to and use of evidence-based tobacco cessation treatments" (page 1). CDC baseline target rate is 6 percent treatment reach, which no state has yet achieved.

Increase the number of health care settings assessed that use the systems approach for tobacco dependence treatment.

Rationale: *The Community Guide* from Community Preventive Services Task Force (August 2012) recommends "quit line interventions, particularly proactive quit lines (i.e. those that offer follow-up counseling calls), based on strong evidence of effectiveness in increasing tobacco cessation among clients interested in quitting" (page 1). Policies and programs changes communicated to health care providers and tobacco users to increase awareness, interest in quitting, and use of evidence-based treatments.

Build Capacity and Infrastructure to Implement a Comprehensive Evidence-Based Tobacco Prevention and Control Program

Maintain the administrative structure to manage the comprehensive North Dakota Tobacco Prevention and Control Program in concurrence with CDC *Best Practices for Tobacco Prevention and Control Programs*.

Rationale: A comprehensive tobacco control program requires considerable funding to implement; therefore, a fully functioning infrastructure must be in place in order to achieve the capacity to implement effective interventions. Sufficient capacity is essential for program sustainability, efficacy and efficiency, and enables programs to plan their strategic efforts, provide strong leadership and foster collaboration among the state and local tobacco control communities. An adequate number of skilled staff is also necessary to provide or facilitate program oversight, technical assistance and training." (*Best Practices for Comprehensive Tobacco Control Programs*, January 2014, p.64)

STATE PLAN GOALS, OBJECTIVES, STRATEGIES AND ACTIVITIES JULY 1, 2017 – JUNE 30, 2019.

Goal 1: Prevent the Initiation of Tobacco Use Among Youth and Young Adults

Objective 1.1: By June 30, 2019, increase the price of cigarettes and other tobacco products by the minimum amount necessary to effectively lower health impacts, excluding FDA approved Nicotine Replacement Therapy products. (Current tax: 44 cents Source: North Dakota Tax Department)

Rationale: According to the campaign for Tobacco-Free Kids, their research shows that each 10 percent cigarette price increase reduces youth smoking by 6.5 percent, adult smoking rates by 2 percent and total consumption by about 4 percent (adjust down to account for tax evasion effects). The Guide to Community Preventive Services, November 2012, pg. 1-2 confirms public health effects are proportional to the size of price increase and scale of intervention." CDC Best Practice for Comprehensive Tobacco Control Programs January 2014 recommends increasing the unit price of tobacco products for preventing tobacco use among youth.

Strategy 1.1.1: Meet with partners and stakeholders to coordinate efforts to move forward with price increase implementation.

Activity: Assist the Tobacco Free North Dakota (TFND) coalition in building capacity to serve as the lead partner in price increase efforts.

Activity: Develop a strategic plan to increase the price of tobacco products.

Activity: Identify and engage local and state community champions willing to support these price increase efforts.

Strategy 1.1.2: Provide resources and guidance for Local Public Health Unit (LPHU) Tobacco Prevention and Control Programs (TPCPs) and Tribal Tobacco Prevention and Control Programs (TPCP) to promote the benefits of tobacco product price increases to their communities.

Activity: Work with LPHUs to develop and expand local coalitions to provide a local voice for community-backed price increase efforts.

Activity: LPHU TPCP coordinators and their local coalitions work to engage local leaders on the importance of tobacco price increase efforts.

Strategy 1.1.3: Work with political subdivisions to designate Electronic Nicotine Delivery Systems (ENDS) as tobacco products.

Strategy 1.1.4: Engage Tribal TPCPs to implement or increase the price of tobacco on North Dakota American Indian (AI) reservations to match or exceed state pricing.

Objective 1.2: By June 30, 2019, the North Dakota Department of Health (NDDoH) and North Dakota School Board Association (NDSBA) comprehensive model tobacco-free school policy will cover 90 percent of Local Education Associations (LEAs) (from 82 percent in 2017. Source: Center for Tobacco Prevention and Control Policy (CTPCP) data).

Strategy 1.2.1: Engage new NDSBA Policy Director to coordinate comprehensive policy efforts.

Activity: Review latest NDDoH and NDSBA model policies for consistency. Update policies as necessary.

Activity: Disseminate updated NDDoH/NDSBA policies to LPHU TPCPs to compare with current school policies in their areas. Activity: Implement updated local school policies with NDDoH/NDSBA policies as needed.

Objective 1.3: By June 30, 2019, increase the number of state and tribal college campuses in North Dakota with tobacco-free grounds policies to 16, adequately addressing ENDS (from 6 in 2017. Source: CTPCP data).

Strategy 1.3.1: Engage North Dakota University System (NDUS) prevention director in policy assessment efforts.

Strategy 1.3.2: Collaborate with LPHU and Tribal TPCPs to work with local state college campuses to assess current policy status and work to strengthen, if necessary.

Objective 1.4: By June 30, 2019, increase to 10 the number of local and tribal TPCPs engaging North Dakota youth to become advocates to counteract tobacco industry marketing influences (from 4 in 2017. Source: North Dakota Department of Health Tobacco Prevention and Control Program (NDDoH TPCP) data).

Strategy 1.4.1: Identify local and tribal TPCPs that have successfully engaged local youth in their advocacy efforts. Strategy 1.4.2: Provide tobacco prevention advocacy training to youth involved in local program activities.

Activity: Utilize tobacco prevention trainings such as the Counter Tools program. Activity: Implement Campaign for Tobacco-Free Kids (CTFK) youth advocacy training.

Strategy 1.4.3: Assess compliance with 2015 state ENDS youth access legislation in local communities.

Strategy 1.4.4: Engage youth in activities related to a tobacco product price increase, including ENDS.

Objective 1.5: By June 30, 2019, reduce to 10 the percentage of retailers selling tobacco products to minors as determined by the Synar tobacco compliance check program (from 17.9 percent in 2015. Source: North Dakota Department of Human Services-NDDHS).

Strategy 1.5.1: Coordinate with NDDHS to provide resources to LPHU TPCPs for Synar-related projects, including law-enforcement trainings.

Strategy 1.5.2: Assess North Dakota communities with youth tobacco-compliance ordinances in place.

Activity: Communities with an ordinance: coordinate with NDDHS to provide guidance and resources for compliance checks.

Activity: Communities with no ordinance: coordinate with NDDHS to provide guidance, resources and training to implement compliance checks.

Goal 2: Eliminate Exposure to Secondhand Smoke

Objective 2.1: By June 30, 2019, eliminate/reduce exposure to secondhand smoke in North Dakota by maintaining the North Dakota Smoke-Free Law as passed in November 2012.

Strategy 2.1.1: Transition smoke-free law compliance coordination with

LPHUs to the NDDoH. Activity: Develop a process to engage

LPHUs in compliance notification processes.

Strategy 2.1.2: Provide smoke-free law signage to businesses that are required to comply with the law.

Activity: Work with the North Dakota Secretary of State's office to provide signage and informational materials to new businesses in North Dakota.

Strategy 2.1.3: Monitor legislative/political activity that may threaten the 2012 Smoke-Free Law.

Activity: Work with state and national partners to monitor potential threats.

Strategy 2.1.4: Monitor areas of influence by the tobacco industry.

Activity: Work with state and national partners to monitor industry activities.

Strategy 2.1.5: Provide resources and technical assistance to partners and stakeholders to assist in smoke-free law advocacy efforts.

Activity: Maintain an updated library of resources to assist partners and stakeholders with

advocacy and education. Activity: Convene a work group to identify training and education

needs for partners and stakeholders.

Objective 2.2: By June 30, 2019, prevent preemption in all North Dakota state tobacco prevention and control laws.

Strategy 2.2.1: Monitor legislative/political activity that may threaten to preempt North Dakota tobacco prevention and control laws.

Activity: Work with the state and national partners to identify potential preemption threats and measures to counter these threats.

Objective 2.3: By June 30, 2019, reduce the number of North Dakotans exposed to secondhand smoke at home by increasing number of smoke- free multi-unit housing policies encompassing 7,500 housing units (from 6,583 housing units in 2016. Source: CTPCP data).

Strategy 2.3.1: Increase the number of smoke-free multi-unit housing properties in North Dakota.

Activity: Assess the number of current smoke-free multi-unit housing policies in North Dakota.

Activity: Provide education and model smoke-free/tobacco-free policies to local multi-unit housing owners and managers in North Dakota.

Strategy 2.3.2: Assist North Dakota public housing units in the implementation of the Housing and Urban Development (HUD) smoke-free policy.

Activity: Assess number of current policies that restrict exposure to secondhand smoke in local public housing units in North Dakota.

Activity: Provide assistance to local public housing operators and managers in North Dakota on implementation of the HUD smoke- free policy.

Objective 2.4: By June 30, 2019, reduce the number of North Dakotans exposed to secondhand smoke at work and by increasing to 4 the number of smoke-free policies and laws in areas not covered by the North Dakota Smoke-Free Law (from 2 in 2017. NDDoH TPCP).

Strategy 2.4.1: Increase the number of smoke-free tribal casinos in North Dakota.

Activity: Work with the Intertribal Tobacco Abuse Coalition (ITAC) to advance the North Dakota Smoke-Free Casino Project.

Objective 2.5: By June 30, 2019 reduce the number of North Dakotans exposed to secondhand smoke in public outdoor areas by increasing to 140 the number of smoke-free policies in areas not covered by the North Dakota Smoke-Free Law (from 126 in 2016. Source: CTPCP data).

Strategy 2.5.1: Increase the number of tobacco-free public recreation areas in North Dakota.

Activity: Assess current local efforts in addressing tobacco use in outdoor public areas not protected by the North Dakota Smoke- Free Law.

Goal 3: Promote Quitting Tobacco Use

Objective 3.1: By June 30, 2019, reduce the number of tobacco users in North Dakota by increasing the annual treatment reach of NDQuits to all North Dakota cigarette smokers to 2.5 percent (from 1.71 percent in 2016. Source: NDDoH TPCP).

Strategy 3.1.1: Increase the number of referrals to NDQuits from health care providers in North Dakota.

Activity: Work with health systems to implement e-Referrals (direct referrals from electronic health records

(EHRs) to NDQuits). Activity: Increase NDQuits Cessation Grantees that implement the Ask, Advise, Refer

protocol and refer to NDQuits.

Activity: Increase referrals from LPHU TPCPs.

Strategy 3.1.2: Expand, leverage, and localize CDC media campaigns, such as *Tips from Former Smokers.*

Strategy 3.1.3: Provide technical assistance and guidance to NDQuits Cessation Grants grantees in health systems on evidence-based strategies that increase the use of cessation services.

Activity: Coordinate referral process to NDQuits.

Activity: Promote and maintain tobacco treatment protocols, such as assessing all patients at each visit.

Activity: Determine reportable variables from EHRs, such as the number of patients assessed for tobacco use, number receiving treatment in-house, and number of patients referred to NDQuits.

Objective 3.2: By June 30, 2019, reduce the number of tobacco users in North Dakota by increasing to 50 the number of health care settings assessed that use the systems approach for tobacco dependence treatment as recommended in the US Public Health Service *Treating Tobacco Use and Dependence, Clinical Practice Update 2008* (from 45 in 2017. Source: NDDoH TPCP data).

Strategy 3.2.1: Provide technical assistance and guidance to NDQuits Cessation Grants grantees in health systems on evidence-based strategies that increase the use of cessation services.

Activity: Coordinate referral process to NDQuits.

Activity: Promote and maintain tobacco treatment protocols.

Activity: Determine reportable variables from EHRs, such as the number of patients assessed for tobacco use, number receiving treatment in-house, and number of patients referred to NDQuits.

Objective 3.3: By June 30, 2019, reduce the number of tobacco users in North Dakota by increasing the percentage of adult smokers in North Dakota who have attempted to quit once in the last year to 57 percent (from 55.8 percent in 2015. Source: North Dakota Behavioral Risk Factor Surveillance System (BRFSS)).

Strategy 3.3.1: Increase the number of referrals to NDQuits.

Activity: Work with health systems to implement e-Referrals (direct referrals from electronic health records

(EHRs) to NDQuits). Activity: Increase NDQuits Cessation Grantees that implement the Ask, Advise, Refer

protocol and refer to NDQuits.

Activity: Increase referrals from LPHU TPCPs.

Strategy 3.3.2: Provide technical assistance and guidance to NDQuits Cessation Grants grantees in healthcare and community health systems on evidence-based health systems changes that increase the use of cessation services.

Activity: Coordinate referral process to NDQuits.

Activity: Promote and maintain tobacco treatment protocols.

Activity: Determine reportable variables from EHRs, such as the number of patients assessed for tobacco use, number receiving treatment in-house, and number of patients referred to NDQuits.

Objective 3.4: By June 30, 2019 increase to 33 the number of health systems and community organizations working to target special populations with tobacco cessation treatment interventions (from 30 in 2017. Source: NDDoH TPCP data).

Strategy 3.4.1: Pregnant women

Activity: Implement the BABY & ME – Tobacco Free Program in health systems.

Activity: Promote the NDQuits Pregnancy Rewards Program to providers and pregnant women to increase use of NDQuits by pregnant tobacco users.

Activity: Maintain support and promotion of the NDQuits pregnancy protocols provided by NDQuits contractor.

Strategy 3.4.2: American Indians

Activity: Establish the NDQuits Cessation Grants Program on at least one reservation.

Activity: Maintain and expand the BABY & ME – Tobacco Free Grant Program on reservations.

Activity: Maintain support and promotion of the American Indian NDQuits protocols provided by NDQuits contractor.

Strategy 3.4.3: Behavioral Health

Activity: Maintain and expand the NDQuits Cessation Grants Program in addiction treatment centers.

Activity: Engage additional public and private behavioral health programs to implement evidence-based cessation interventions.

Strategy 3.4.4: Young adults ages 18-24

Activity: Maintain and expand the NDQuits Cessation Grants Program in college campus health clinics.

Strategy 3.4.5: Low Socioeconomic Status (SES)

Activity: Maintain and expand the NDQuits Cessation Grants Program in Federally Qualified

Health Centers (FQHC). Activity: Engage North Dakota Medicaid to streamline tobacco cessation treatment for patients.

Strategy 3.4.6: Cancer Survivors

Activity: Maintain and expand the NDQuits Cessation Grants Program in cancer treatment centers.

Strategy 3.4.7: Lesbian, Gay, Bisexual, Transgender (LGBT)

Activity: Promote cessation services at LGBT events and through targeted media.

Activity: Engage LGBT community leadership to integrate cessation interventions into LGBT population health initiatives.

Goal 4: Build Capacity and Infrastructure to Implement a Comprehensive Evidence-Based Tobacco Prevention and Control Program

Objective 4.1: By June 30, 2019, maintain the administrative structure to manage the comprehensive North Dakota Tobacco Prevention and Control Program in concurrence with CDC *Best Practices for Tobacco Prevention and Control Programs*.

Strategy 4.1.1: Update the North Dakota Comprehensive Tobacco Prevention and Control Plan to reflect program changes defined by the 65th North Dakota Legislative Assembly.

Strategy 4.1.2: Provide adequate staffing for key TPCP positions to maximize effectiveness of available Full-Time Equivalent (FTE) positions.

Objective 4.2: By June 30, 2019, maintain and enhance infrastructure and capacity to collaboratively deliver evidence-based tobacco prevention and control interventions from the most current CDC *Best Practices for Comprehensive Tobacco Control Programs*.

Strategy 4.2.1: Engage key partners and stakeholders in plan update activities and strategic planning efforts.

Strategy 4.2.2: Provide funding to key partners and stakeholders to implement plan activities.

Strategy 4.2.3: Utilize CDC-approved training resources in TPCP planning and community

engagement activities. Strategy 4.2.4: Convene strategic planning sessions to coordinate

state plan activities as needed.

Strategy 4.3.5: Form a North Dakota Comprehensive Tobacco Prevention and Control Plan review team to assess needs for plan changes/updates.

Objective 4.3: By June 30, 2019, maintain effective, ongoing tobacco prevention and control health communication initiatives that focus on changing the broad social norms of tobacco. The communications initiatives will deliver strategic, culturally appropriate and high-impact earned and paid messages through sustained and adequately funded campaigns integrated into the overall comprehensive North Dakota Tobacco Prevention and Control Plan.

Strategy 4.3.1: Update the North Dakota Comprehensive Tobacco Prevention and Control Communications Plan.

Strategy 4.3.2: Coordinate media efforts between NDDoH, Tobacco-Free North Dakota (TFND) and the Public Education Task Force (PETF) to provide cost-effective health communications.

Strategy 4.3.3: Work with a media vendor to coordinate state tobacco prevention efforts.

Activity: Identify appropriate media messaging. Activity: Conduct cost-effective, impactful media buys. Activity: Keep documentation of media efforts.

Strategy 4.3.4: Develop and promote local coalition-based messaging relevant to local tobacco prevention issues.

Objective 4.4: By June 30, 2019, update the North Dakota comprehensive statewide surveillance and evaluation plan.

Strategy 4.4.1: Update the North Dakota State Comprehensive Tobacco Prevention and Control Evaluation Plan to reflect program changes.

Strategy 4.4.2: Engage our new contractor in updating the Evaluation Plan.

Strategy 4.4.3: Evaluate NDDoH tobacco programs and disseminate results

Strategy 4.4.4: Fund and implement tobacco-related surveys

Activity: Adult Tobacco Survey (ATS), Youth Tobacco Survey (YTS), etc.

Strategy 4.4.5: Coordinate with partners to continue data collection efforts with tobacco program involvement.

Activity: ATS, YTS, Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring System (PRAMS), etc.

Strategy 4.4.6: Serve as a resource for tobacco-related data.

Activity: ATS, YTS, Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring System (PRAMS), etc.

Activity: Provide data to partners and the public through websites, surveillance tables, publications, etc.

Strategy 4.4.7: Work with evaluation contractor to provide an independent review of the North Dakota State Comprehensive Tobacco Prevention and Control Plan and present to North Dakota Legislative Management during the 17-19 biennium.

Objective 4.5: By June 30, 2019, update sustainability efforts previously described in the latest version of the North Dakota Comprehensive Tobacco Prevention and Control Plan.

Strategy 4.5.1: Coordinate and support the work of TFND, LPHU TPCPs, local coalitions, and other partners and stakeholders relating to the State Plan.

Strategy 4.5.2: Utilize media to promote the work and successes of the State Plan.

Strategy 4.5.3: Provide communication on the status of State Plan efforts to stakeholders and decision makers.

Strategy 4.5.4: Coordinate State Plan efforts with NDDoH objectives/strategies/activities described in the CDC Office on Smoking and Health state tobacco prevention grant program provided to North Dakota.

Strategy 4.5.5: Promote the value of the North Dakota State Comprehensive Tobacco Prevention and Control Plan to decision makers and the citizens of North Dakota.

D. Evaluation Methodology Tables

This section of the evaluation report does not currently reflect all evaluation questions and will be revised throughout FY19, as the evaluation priorities continue to take shape.

Cessation Interventions

NDQuits FY18 Evaluation & Analysis Plan

Dataset 1: All referrals from FY18 (July 1, 2017 – June 30, 2018).

Dataset 2: All unique tobacco users registered for services in FY18 (July 1, 2017 – June 30, 2018) with FY program utilization.

Dataset 3: All unique tobacco users registered for services in follow-up cohort January 2017 – December 2017.

Dataset 4: All unique respondents to quit survey in FY15, FY16, FY17, FY18 with 7-month phone, web, medication and text utilization.

Evaluation Area	*Evaluation Questions*	*Data Sources*
Connecting to NDQuits	How did enrollees learn about NDQuits in FY18? How did enrollees connect with NDQuits in FY18?	Dataset 1 Client Data Extract Referral Details Extract
Enrollment & Reach	How many unique tobacco users registered for: • General protocol • Pregnant protocol • American Indian (AI) protocol • Overall What was the reach of NDQuits in FY18?	Dataset 2 Client Data Extract Event Details Extract Medications Extract BRFSS 2017 ND ATS 2017 Census 2017
Participant Characteristics	What were the NDQuits participant characteristics in FY18? How do these compare to ND tobacco user characteristics overall?	Dataset 2 Client Data Extract BRFSS 2017 ND ATS 2017

Program Use	What were patterns of use for NDQuits participants in FY18? • Do these differ by program (general vs. AI, and general vs. pregnant) • How many pregnant-tailor registrants complete all five pre-natal calls? ($5/pre) • How many pregnant -tailor registrants complete 4-postpartum? ($10/post)	Dataset 2 Client Data Extract Event Details Extract Text Extract Web Utilization Extract
Medication Provision	What were patterns of NRT provision and use in FY18? • Does this differ by program? (general vs. AI)	Dataset 2 Client Data Extract Medications Extract Dataset 3 7-month Follow-up (January – December 2017 registrations)
Patterns of ENDS use?	What were the patterns of electronic nicotine devices (ENDS) use?	Dataset 2 Client Data Extract Dataset 3 7-month Follow-up (January – December 2017 registrations)
Program Outcomes	What were program quit outcomes? To what extent were participants satisfied with the services received in FY18?	Dataset 3 7-month Follow-up (January – December 2017 registrations) Client Data Extract Event Extract Text Extract Medication Extract Web Utilization Extract Dataset 4 Logistic model cohort dataset
Cost Benefit Analysis		Uses a mixed dataset: - ATS, SAMMEC - NDQuits FY18 intake & utilization - NDQuits Outcome dataset

BMTF

Evaluation Area	Evaluation Questions	Evaluation Methods
Program enrollment	How many people enrolled in the BMTF program in North Dakota in CY17 and overall? How does this compare to previous years?	Enrollments were summarized using descriptive statistics (counts and frequencies) overall, by grantee, and by calendar year. Differences in enrollments by grantees over time was assessed using a chi square test.
Participant characteristics	What are the demographic and tobacco use characteristics of those who enroll in BMTF? Have these characteristics changed over time? How do these characteristics compare to pregnant tobacco users statewide? How many are referred, at any point in the program, to NDQuits?	Participant demographics and tobacco use characteristics were summarized overall, by grantee, and by calendar year. Chi square tests (or Fisher's exact tests if any expected cell count <5) were used to test for differences in demographics and tobacco use characteristics by grantee and by calendar year. ND vital statistics for 2016 were used to compare race, ethnicity, education, health insurance, age, and cigarettes smoked per day between participants in BMTF to statewide characteristics of women who were pregnant and gave birth in 2016.
Program use	On average, how much time did counselors spend with clients across all sessions? How many enrollees returned to each BMTF prenatal session? What proportion complete each time point out of those eligible for each time point? How many enrollees complete all four prenatal sessions with a counselor (overall and by grantee)? How many enrollees returned to each BMTF postnatal session? What proportion completed each time point out of the eligible for each time point. On average, how many total postpartum sessions were completed per participant?	Number of sessions attended prenatal/postpartum was summarized with descriptive statistics (mean, median, standard deviation, and min and max). Prenatal and postpartum session attendance by grantee were assessed using ANOVAs with post hoc pairwise comparisons with a Bonferroni adjustment. Prenatal session attendance by calendar year was assessed using an ANOVA with post hoc pairwise comparisons with a Bonferroni adjustment, but only for those who had enough time to accumulate 4 prenatal sessions. Postpartum session attendance by calendar year was assessed using a two-sample t-test (only for calendar years 2015 and 2016).

Program outcomes	What were participants prenatal cessation patterns? How many participants were abstinent at least once during prenatal sessions 2 thru 4? What were participants postnatal cessation patterns? What were average birth weights overall and by grantee? How do these birth weights compare to pregnant tobacco users statewide? What was the average gestational age overall and by grantee? (FY19 only) How do these gestational ages compare to pregnant tobacco users statewide? (FY19 only)	ND vital statistics for the year 2016 were used to compare baby birth weight between participants in BMTF to statewide characteristics of women who were pregnant and gave birth in 2016. Data are from moms with live births and fetal deaths. Birth weight from vital statistics was provided in grams but converted to pounds. A two-sample t-test was run using SPSS to compare BMTF baby birthweights to Vital Statistics baby birthweights (in pounds).
Impact of dedicated counselors on program attendance and abstinence	Does a dedicated counselor impact prenatal/postpartum abstinence? Does a dedicated counselor impact the number of sessions attended? Does a dedicated counselor impact the average time spent with clients?	(FY 19)

North Dakota Quit Cessation (NDQC) Grantees

Evaluation Area/ Report Section	Evaluation Question/ Report Subsection	Data Source(s)	Analysis
1: Tobacco Treatment Program	A. To what extent have NDQC grantees established or maintained a Tobacco Treatment Program in-house with trained TTS? What is the approach of each grantee to implement tobacco cessation services in their healthcare systems? B. What are the unique approaches to tobacco treatment and/or treatment contexts across grantees? What are the common tobacco treatment approaches across grantees? C. How many new TTS have been trained over the fiscal year? How many have maintained a prior TTS certification? D. To what extent have NDQC grantees established or maintained billing practices that will help sustain the Tobacco Treatment Program? E. What are the challenges and successes of using electronic medical records to track data related to the NDQC efforts?	Grantee work plans, grantee interview summaries, grantee FY18 planning documents, & quarterly progress report data	Qualitative summaries of interview documents & work plans e-referral progress Count of TTS (FY18 overall and by quarter) across all grantees Count, percent, and description of billing practices Qualitative summary from grantee interviews, planning document, & comments on quarterly progress report
2: Program Delivery and Outcomes	**Tobacco Screening:** A. What percent of patients are being screened for tobacco use? Of those, what percent are tobacco users? How has this changed over time? B. How are grantees advising tobacco users to quit? C. Are tobacco users being pre-screened for lung cancer? **Program Utilization:** D. How many total TTS visits occur over the fiscal year, across grantees?	Grantee FY18 planning document & quarterly progress report data	For tobacco screening and program utilization, frequencies and percentages for FY18 overall and by quarter across all grantees. Grantee-specific tobacco screening and program utilization data For comparisons over time, FY17, FY16 PDA evaluation reports will be used.

Evaluation Area/ Report Section	Evaluation Question/ Report Subsection	Data Source(s)	Analysis
	E. To what extent are patients receiving bridge nicotine replacement therapy (NRT)? How has this changed over time? F. To what extent are patients referred to NDQuits? How has this changed over time? **Program Outcomes:** G. What successes are grantees reporting? H. To what extent have patients quit using tobacco? **		A summary of program successes will be provided with a list of the success stories from quarterly reports will be provided. **While follow-up is no longer required, a couple sites are still doing it. If there is sufficient n, we will report on quit outcomes.
3: Education	A. What types of educational tobacco trainings are taking place? B. How many events occurred? C. How many attended events over the fiscal year? D. What was the feedback related to the events?	Quarterly progress report data, educational event information supplied by DoH via email, and education event evaluation forms, if available	An overall summary will be included in report as well as a full description of each event.
4: Grantee Profiles	A. What is the individual grantee's program impact? (Relevant metrics from report sections 1 and 2) B. Did the grantee meet their goals for program utilization?	Grantee work plans, grantee interview summaries, grantee FY18 planning	Description of grantee individually (i.e. each grantee will have its own sub-section).

Evaluation Area/ Report Section	Evaluation Question/ Report Subsection	Data Source(s)	Analysis
	C. What key measures are the grantees opting to track? D. What are the results of these efforts? E. What are the context-specific successes and challenges experienced by each grantee?	documents, & quarterly progress report data	

❷ State and Community Interventions

Evaluation Question	Information Needed	Information Source	Methods	Timing of Use
What is the collective effort of the LPHUs in working toward the goals and objectives set forth in the North Dakota State Tobacco Plan?	- Activities conducted and how they contribute to the State Tobacco Plan objectives	- LPHU Quarterly Reports - ND State Tobacco Plan	- Analysis of quarterly report data -Document review	-Full FY18 report delivered Sept. 2018.
What are key success stories from the work at the local levels?	-Successes from activities reported.	- LPHU Quarterly Reports Qualitative Data	- Analysis of quarterly qualitative report data	-Qualitative data analysis of quarterly report data begins Jul. 16th. -Full FY18 report delivered Sept. 2018.
To what extent are key priority populations effectively reached by grantees? In what ways are these key populations being engaged?	-Who LPHUs are serving -Activities engaging priority populations -Effectiveness of these efforts	- LPHU Quarterly Reports -Demographics of populations served	- Analysis of quarterly report quantitative data	-Full FY18 report delivered Sept. 2018.
What are the key barriers with the work at the local levels?	-Challenges specific to local level work	- LPHU Quarterly Reports	- Analysis of quarterly report qualitative data	-Qualitative data analysis of quarterly report data Jul. 16th. -Full FY18 report delivered Sept. 2018.
How is capacity being built across the state among community interventions, to promote collaboration, sharing, and shared learning? (workgroups, CDC Best Practices Training, TFND, Quarterly in-person meetings.)	-Coalition building activities -Trainings conducted, meetings attended -Quarterly Tobacco prevention and cessation meetings	- LPHU Quarterly Reports -CDC Best Practices document -Interview data -Quarterly meeting agenda/notes	- Analysis of quarterly report data -Analysis of interview data -Document review	-Qualitative data analysis of quarterly report data begins Jul. 16th. -Full FY18 report delivered Sept. 2018.

❸ Health Communication Interventions

Evaluation Question	*Information Needed*	*Information Source*	*Methods*	*Timing of Use*
What media efforts have been undertaken across platforms and how do they align with CDC Best Practices in Tobacco Control?	- CDC Best Practices - Descriptions of media efforts across platforms - Examples of media	-CDC Best Practices document -Interview data	- Analysis of interview data -Document review	-Interviews should be conducted by 5/16 - Final report due 6/29
What are the tobacco communications priorities following the transition of all tobacco programming to NDDoH in FY18? How ere resources optimized given limited funding?	-Strategic decisions -Successes/challenges -Intentions for FY19.	-Interview data	- Analysis of interview data -Document review	-Interviews should be conducted by 5/16 - Final report due 6/29

❹ Surveillance and Evaluation

Evaluation Question	*Information Source*	*Methods*	*Timing of Use*
What are the data and information gaps, particularly in relation to monitoring progress on the North Dakota State Tobacco Plan?	-CDC Best Practices document -Interview data	- Analysis of interview data -Document review	Incorporated into the synthesis report; delivered to NDDoH in January 2019
To what extent are surveillance and evaluation efforts coordinated to effectively and efficiently meet the needs of the primary intended users?	-Interview data	- Literature Review	
To what extent have surveillance and evaluation activities been integrated into programmatic and strategic activities? To what extent is evaluation responsive to the changing needs of the programmatic and strategic work in the state?			
To what extent are the following trends monitored? To what extent is the following information made available for public use? *i. Preventing initiation among youth and young adults* *ii. Trends in promoting quitting* *iii. Trends in exposure to secondhand smoke* *iv. Economic impact of tobacco* *v. Tobacco-related disparities among key priority groups*			
What additional data collection systems or approaches are needed to adequately capture the outcomes of key priority groups (American Indians, lesbian, gay, bisexual, transgender, queer (LGBTQ), pregnant women, residents served by Medicaid, and smokeless tobacco users)?			

❺ Infrastructure, Administration, and Management

Evaluation Question	*Information Source*	*Methods*	*Timing of Use*
To what extent did NDDoH engage in strategic planning work following the legislative changes and reduction of funding to tobacco control starting in FY18? What was the nature of strategic planning efforts? What are the key lessons learned?	-CDC Best Practices document -Participation in sustainability assessment, follow-up calls and work -Review of workgroup activities, progress on shared site	- Analysis of interview data -Document review - Literature Review	Incorporated into the synthesis report; delivered to NDDoH in January 2019
To what extent is tobacco control integrated into various chronic disease initiatives at the state? At the local levels? At the national level (e.g., NACDD)?			
To what extent does NDDoH increase capacity at the local level to engage in tobacco control efforts? What are the successes and barriers of these efforts?			
To what extent does NDDoH engage in strategic planning efforts around tobacco control?			
What is the result of a coordinated tobacco prevention and cessation effort? What is the value to the state as a result of this coordination?			